Webinar Questions and Answers
Anthem Blue Cross and CVS Caremark

Q: How long can one be outside of the state and receive care? Must one notify you when leaving the state/going on vacation?

A: This concern does not apply to the PPO plans. Most CalPERS under age 65 retirees who live out of state are enrolled within PERSCare and PERS Choice. This is a HMO oriented question.

Q: Is the calendar year maximum a family or individual maximum?

A: Both. The coinsurance maximum for PERS Choice is $3,000 per member and $6,000 per family unit.

Q: We are an out-of-area group and we use PERS Choice and PORAC only. Our employees have started to pay a portion of the premium this year and I think people will be interested in PERS Select. As an out-of-area group, how will PERS Select be different from PERS Choice for our employees?

A: The PERS Select plan utilizes a subset of the full Anthem Blue Cross PPO physician network (i.e. 30,000 of the 55,000 Anthem Blue Cross California PPO physicians are designated as "PERS Select" physicians). Members need to confirm that all physicians to be utilized are "PERS Select" providers prior to services being rendered. Also, there are benefit differences for the tiered hospitals under PERS Select.

Q: Is the copay & Calendar Year Max: for each family member and how does the family member know who has reached the max and who has not?

A: The annual deductible and maximum out-of-pocket (i.e. 20% coinsurance obligation) are tracked on the Explanation of Benefits (EOB) statement that is mailed to members upon processing of each claim. EOB's can also be accessed via the web at anthem.com/ca/calpers.

Q: In reference to the Value Based Site of Care (VBSOC), we do not have ambulatory surgical centers in our rural area. How will that work for us?

A: If there are no participating Ambulatory Surgical Centers within the established mileage radius (i.e. 30 miles or 30 minutes driving time from work or home), the physician can contact Anthem Blue Cross to obtain authorization to perform the service at the nearest participating hospital. This review needs to be completed prior to services being rendered.

Q: Can you provide more information on the PPO discount programs (i.e. weight loss programs, club membership, etc.)?

A: All the available programs are included within our CalPERS microsite www.anthem.com/ca/calpers. I would suggest contacting our dedicated CalPERS customer service for all the discount programs' details.

Q: Why is there no hospital in Santa Barbara County offered for hip or knee replacement?

A: Current CalPERS utilization data does not identify a facility that consistently performs both of these procedures under the established payment threshold. Travel benefits are available for members who reside more than 50 miles from the nearest identified VBPD facility. Please call customer service for details.

Q: The FDA now recommends the shingles vaccine for ages 50 and over. Will this vaccine be covered under Anthem Blue Cross for age 50 and over participants?

A: Shingles vaccine would be covered as recommended by the member's physician. It will not be limited to just persons ages 50 and over. As required by Health Care Reform, we are required to cover preventive care services as provided and recommended by the member's physician.

Q: I would like information on the PPO provider network in San Mateo County for the PERS Select plan.

A: The full San Mateo county PERS Select network is available through the CalPERS microsite www.anthem.com/ca/calpers by clicking on the "Find a Doctor" link. This link will then transfer you to a page where PERS Select provider information is accessible. Please click on the PERS Select plan indicator.

Q: What is the difference between PERS Choice & PERS Select?

A: PERS Select can provide the same benefit coverage as PERS Choice, but the member must use PERS Select physicians and the Tier One Select hospital network.

Q: For PPO plans, is $3,000 the maximum per year that a member may pay regardless of health services provided?

A: Under PERS Choice coverage, the maximum plan costs a member may encounter in a calendar year are;

- applicable copays
- the $500 deductible and
- $3,000 on the 20% coinsurance liability.

All these member costs assume participating providers are used.

Q: I've personally had trouble finding a doctor/specialist in my area in PERS Select. Just how many less doctors are in the PERS Select Plan versus PERS Choice, and is that difference in available doctors the major reason for the difference in premium of the two plans?

A: PERS Select benefits feature a subset of the full Anthem Blue Cross participating physician network and a tiering of Anthem Blue Cross contracted hospitals. Approximately 30,000 of the approximate 55,000 Anthem Blue Cross PPO physicians are included within the PERS Select plan. 176 of the approximate 370 contracted hospitals are noted as Tier One facilities. The percentage of PERS Select physicians varies for each individual California county.

Q: Has the list of value based hospitals changed from 2011 to 2012 under Anthem Blue Cross for hip and knee replacement surgery?

A: Effective July 1, 2011, we were pleased to add Community Hospital of the Monterey Peninsula (CHOMP) to the Value Based Purchasing Design list of identified facilities. Future updates will be communicated accordingly.

Q: Why is there an out-of-pocket cost for cataract surgery?

A: Cataract surgery, and any other surgery, is subject to the annual $500 deductible followed by the percentage based benefit specific to your plan (e.g. 80% coverage under PERS Choice). Effective in 2012, we are introducing the Value Based Site of Care (VBSOC) program which places a maximum plan payment of $2,000 on cataract surgeries performed in the Outpatient setting of a hospital. Members will be responsible for their deductible and coinsurance plus any allowable charges in excess of $2,000. There will be no maximum placed on cataract surgeries performed in Participating Ambulatory Surgical Centers.

Q: Please explain the mail order copay again. Currently I am paying $75 for 90-days, which would be $75 for a 30-day supply at the pharmacy?

A: If you fill a prescription for up to a 90-day supply at either CVS Caremark mail service or at a local CVS pharmacy, your new preferred brand copay will be $40 and the non-preferred brand copay will be $100. Typically you use the retail pharmacy for your short term or acute medication needs such as antibiotics.

If you do receive 30-days' worth of a long term or maintenance medication at a retail network pharmacy, you can do this up to 2 fills at the regular copay. However, if you choose to fill a 30-day supply of that maintenance medication at a retail network pharmacy a 3rd time, you will be charged the mail service copay. So, it is a better value and more convenient to fill your long term or maintenance medication through either our mail service pharmacy or at a CVS retail pharmacy.

Q: Do I understand correctly that the copay for brand name drugs is going up by $5, and we will be responsible for the difference between the generic and brand name drug?

A: Brand copays will be increasing for the 2012 plan year. Your generic copays will remain the same at $5 for a 30-days' supply and $10 for a 90-day supply. The brand copays will change for a 30-day supply to $20 for a preferred brand or $50 for a non-preferred brand. If you fill a prescription for up to a 90-day supply at either CVS Caremark mail service or at a local CVS pharmacy, your new preferred brand copay will be $40 and non-preferred brand copay will be $100.

A benefit change for 2012 will be to medications that are dispensed as a brand when a generic equivalent is available. This is called the "Member Pays the Difference" program. If you choose a brand medication when a generic equivalent is available, you will pay the generic copay plus the difference in medication cost between the brand and generic. Remember, you don't have to get a brand name medication just because the prescription has "dispense as written" on it. It's your choice to get the prescription filled with either the brand or its generic equivalent.

To find out if your medication has a generic equivalent, please visit caremark.com/calpers after October 1st to use the "check drug cost" feature or you can call customer care and they will be glad to look it up for you.

Q: What is a lifestyle enhancement medication? Are you referring to Viagra?

A: The CalPERS benefit does not have a category for Lifestyle Medications. We do have a coverage tier established for Discretionary Drugs. These are drug products used to treat non-life threatening conditions such as Erectile Dysfunction. Erectile Dysfunction medications covered under the plan would pay with a 50% coinsurance.

Q: Is it up to the Individual to make sure there is NOT a generic drug available when they receive a prescription from a Doctor?

A: It is always a good idea to talk with your doctor about generic medications available to treat your condition. If you would like to take the generic equivalent when your doctor writes a prescription, please ask them not to indicate "Dispense as Written or DAW" on the prescription. This will allow your Pharmacist to fill the prescription with the generic equivalent. It is also a good idea to make sure your Pharmacist knows you would like to use the generic form of a medication when it is available.

Q: Is the Pharmacy Benefit Manager the same as the mail order provider?

A: In this case, yes. CVS Caremark is the Pharmacy Benefit Manager that will manage all of the prescription needs for CalPERS PPO plan members. This would include those filled at a retail pharmacy, the CVS Caremark Mail Service Pharmacy or the CVS Caremark Specialty Pharmacy.

Q: Are members required to go to a CVS pharmacy or can they go elsewhere?

A: No, you are not required to use a CVS/pharmacy for your retail prescriptions. The CVS Caremark network has over 64,000 in-network pharmacies to choose from. To locate the in-network pharmacies in your area, visit www.caremark.com/calpers after October 1st.

Q: Will CVS Caremark be the Prescription Provider for PORAC?

A: CVS Caremark will be the Pharmacy Benefit Manager for those members enrolled in the Anthem PPO plans.

Webinar Questions and Answers
Blue Shield of California

Q: How does one know if a pharmacy is within the network?

A: To find out if your local pharmacy is included in our retail pharmacy network, visit our *Find a Provider* tool at **blueshieldca.com**. Click *find a provider now* and then select *pharmacies*. You can also call Member Services at **(800) 334-5847.**

Q: What is the definition of "network"?

A: "Network" is defined as your primary care physicians, affiliated specialists, and hospital network which comprise your Individual Physicians Association (IPA).

Q: Will Costco be in the new pharmacy program?

A: Yes. To find out if your local pharmacy is included in our retail pharmacy network, you can visit our *Find a Provider* tool at **blueshieldca.com**. Click *find a provider now* and then select *pharmacies*.

In addition to offering a large pharmacy network that includes chains such as Walgreens, CVS, Rite Aid, and Costco, we feature PrimeMail -- a convenient mail-order prescription service.

Q: If an employee is out of the area and is using emergency or urgent care, will the employee have to pay out of pocket, then be reimbursed for services?

A: If services are not received from a Blue Shield of California Plan provider, you may be required to pay the provider for the entire cost of the service and submit a claim to the Blue Shield Access+HMO or NetValue HMO. Claims for urgent services obtained outside of your Personal Physician service area within California will be reviewed

retrospectively for coverage. When you receive covered urgent services outside your Personal Physician service area within California, the amount you pay, if not subject to a flat dollar copayment, is calculated on Blue Shield's allowed charges. Please refer to the *Evidence of Coverage & Disclosures* booklet for more information.

Outside of California, you can receive emergency and urgent care from doctors and hospitals while on vacation or traveling for business anywhere in the world. And, if you use the BlueCard® Program, you will pay only your regular copay at the time of service and will not have any claim forms to fill out when you return.

Providers in more than 200 countries belong to the BlueCard Worldwide® Network, and 85% of providers in the United States belong to BlueCard's national network. Of course, you should always call 911 or seek care at the nearest medical facility if you reasonably believe that you have a medical condition that requires an emergency response.

Q: Is "Away From Home Care" new?

A: No. The Away From Home Care (AFHC) program provides HMO benefits for members who are away from home for extended periods of time. Membership eligibility is applicable to spouses, domestic partners and dependents who are away from home for at least 90-days, or to members who are away from home for at least 90-days but not more than 180 days.

Away From Home Care is available in 33 states; HMO benefits vary by state. AFHC offers benefits with a local ID card, and there is no additional charge to the member. Call **(800) 622-9402** for more information about coverage.

Q: How does someone "self-refer" themselves to a specialist? Are there any forms they need to fill out prior to making the appointment?

A: You may arrange an office visit with a Plan specialist in the same medical group or IPA as your Personal Physician without a referral from your Personal Physician, subject to certain limitations. *Access+ Specialist* office visits are available only to members whose Personal Physicians belong to a medical group or IPA that participates as an *Access+ Specialist* provider.

Refer to the Access+HMO or NetValue HMO Physician and Hospital Directory or call Blue Shield Member Services at **(800) 334-5847** to determine whether a medical group or IPA is an *Access+ Specialist* provider. If they are, you simply call for an appointment; you do not need to complete any forms.

Q: What is the average time between the initial call to the doctor and the first appointment? What is the average time between primary recommendation and ability to get second appointment?

A: The following table provides the general timeframes/standards associated with Access to Care:

Type of Access - Routine, non-urgent, symptomatic care appointment with assigned PCP.
General Standard - Within 7 calendar days.

Type of Access - Routine, non-urgent, symptomatic care appointment with assigned PCP.
General Standard - Within 7 calendar days.

Type of Access - Routine, non-symptomatic or preventive care with a PCP, nurse practitioner or physician assistant at the same office site as the assigned PCP.
General Standard - Within 30 calendar days.

Type of Access - Access to a routine, non-urgent, symptomatic care appointment with specialists.
General Standard - Within 14 calendar days.

Type of Access - Access to an urgent care appointment with the PCP, specialist, covering physician, or urgent care provider.
General Standard - Within 24 hours.

Q: Will CalPERS employees have to change from the Blue Shield Access + HMO Plan to Blue Shield 65 Plus if they are 65 years old upon retirement? If they don't, what happens? Will they lose coverage?

A: Employees turning 65 and becoming Medicare-eligible, retiring from CalPERS and residing in the Blue Shield 65 Plus plan service area, will need to enroll in Blue Shield 65 Plus in order to not impact their medical and prescription drug coverage through CalPERS.

Q: I am a member of the Healthy Lifestyle Rewards Program. I gave up 2 years ago because I have trouble logging in. I contacted the tech support to no avail. Can you help with this?

A: If you need help with registering or logging in to the Healthy Lifestyle Rewards program, please call us toll free at **(877) 932-3375,** Monday-Friday, 8 a.m. to 5:30 p.m. PST. You may also send an email to webdesk@blueshieldca.com.

Along with a description of the problem, make sure to include your full name, subscriber ID, and daytime phone number. We will respond to your email inquiry within three business days.

Q: Will you notify Blue Shield members affected by the Blue Shield 65 Plus enrollment requirements?

A: Yes. Blue Shield will be sending notification to current Blue Shield members who

reside in the Blue Shield 65 Plus service area and are enrolled in the Blue Shield Access + HMO Plan or Blue Shield NetValue HMO Supplement to Original Medicare Plan. The notification will include plan information for Blue Shield 65 Plus, instructions for how to enroll and/or to "opt out" of coverage, enrollment requirements, and important dates.

Q: For those employees who live in Santa Barbara County -- how will they find out that they no longer have access to the NetValue Plan?

A: We will no longer be offering the NetValue plan in Santa Barbara County in 2012. For those members who are impacted by this exit, we will be sending a letter advising of this change.

Blue Shield will continue to offer the Access+ HMO plan in Santa Barbara. Members who were previously enrolled in the NetValueHMO plan with Santa Barbara Select IPA will be able to continue to use those physicians under our Access+ HMO plan.

Q: Most retail pharmacies now offer reduced cost for a 90-day supply of medication. However, it seems like this is only an option through PrimeMail if you have Blue Shield. Is this correct?

A: Yes. Blue Shield of California provides access to pharmacy mail services through PrimeMail, an independent mail-service pharmacy, offering you both savings and the convenience of receiving up to a 90-day supply of covered maintenance drugs delivered to your home or office, with no charge for shipping.

Q: Is "Health Care Partners" available to Blue Shield members in 2012?

A: Yes, this group will be available only under the Access+ HMO plan.

Q: Why are hospitals in Ventura County not participating in the HMO knee and hip replacement coverage?

A: We selected the Preferred Centers based on quality and cost considerations. Each center had to first meet the quality criteria required by the Blue Distinction Program, which awards national recognition by the Blue Cross Blue Shield Association to facilities that provide distinguished clinical care and processes. The centers meeting these quality criteria must also provide this care cost-effectively.

Although there are no centers in Ventura County, there are several in neighboring counties: Arroyo Grande in Arroyo Grande, Huntington Memorial in Pasadena, and Torrance Memorial in Torrance.

Q: Will Blue Shield or CalPERS tell a retiree when they need to sign up for Blue Shield 65 Plus if they are in one of the available counties? Or will it seamlessly transfer?

A: Yes. Blue Shield will be sending notification to current Blue Shield members who reside in the Blue Shield 65 Plus service area and are enrolled in the Blue Shield Access+ HMO Plan or Blue Shield NetValue HMO Supplement to Original Medicare Plan. The notification will include plan information for Blue Shield 65 Plus, instructions for how to enroll and/or "opt out" of coverage, enrollment requirements, and important dates. If the member does nothing and does not "opt out" of Blue Shield 65 Plus coverage, they will be automatically enrolled in Blue Shield 65 Plus for a January 1, 2012 effective date.

Q: If a member has another health plan (offered through spouse's employment) how does coordination of benefits work for each of the 3 plans? Is one option (PPO) a better choice for coordinating benefits?

A: Assuming the member is a CalPERS Eligible Employee, the Blue Shield coverage would be primary for this individual. Normally primary coverage will apply copays, then, based upon the Coordination of Benefits of the secondary coverage, copayments and any non-covered expenses would be processed according to the secondary plan benefits. HMO members must follow the delivery rules for the HMO, otherwise the services may be denied.

For more information, members should consult their *Evidence of Coverage and Disclosure Form* for their HMO plan or call Member Services at **(800) 334-5847**.

Q: I understand that members can use the employer zip code versus their own zip code when enrolling. If the employee uses the employer zip code in say the LA area but live in the Other Southern CA area, can they still go to the doctor in the Other Southern CA area or are they restricted to the LA area?

A: You must live or work in the service area(s) identified in the EOC to enroll in this Plan and to maintain eligibility in this Plan. If you choose to enroll in the Plan based on your work ZIP code because your home is not within a service area, you and each enrolled dependent will be obligated to travel to providers located within the service area you have selected to receive non-emergency care. You, as the subscriber, and each of your enrolled dependents must select providers within the service area in which you enroll; however, if a dependent also works within the plan's service area, that dependent should select a provider which is near his place of work. A dependent who does not reside within the State of California cannot be enrolled in the Plan, except for a child covered by a support order.

The intent of this rule is to provide flexibility for those CalPERS members who reside in a community that is not within the service area of the plan, but where the subscriber works in a nearby community that is within the plan's service area. However, providers cannot effectively coordinate care for patients who do not reside or work near the provider's service area, and may decline to accept a member due to lack of proximity.

When enrolling in Blue Shield 65 Plus, the member must use the zip code of their permanent personal residence for enrollment. Using the employer zip code or a PO Box zip code is not allowed.

Webinar Questions and Answers
Kaiser Permanente of CA

Q: Urgent/Emergency care outside of CA: How long can one be outside of the state and receive care? Must one notify Kaiser when leaving the state/going on vacation?

A: You are not required to notify Kaiser if you are traveling. If you have an emergency or urgent care event please go to your nearest facility for treatment and contact Kaiser as soon as possible.

Q: Please explain the mail order copay again. Currently I am paying $75 for a 90-day supply, which would be $75 for a 30-day supply at the pharmacy?

A: In 2012 if you pick up a 100-day supply (3 months) of a brand name medication in the pharmacy you will pay 3 copays of $20, which would total $60. If you order your brand medication through the mail you will pay $40 (2 copays of $20) for up to a 100-day supply.

Q: Do I understand correctly that the copay for brand name drugs is going up by $5, and we will be responsible for the difference between the generic and brand name drug? Thanks.

A: Correct. Brand name medications are $20 for every 30-day supply in 2012 which is an increase of $5 from 2011.

Q: What is a lifestyle enhancement medication?

A: Lifestyle enhancement drugs are usually medications for the treatment of erectile dysfunction. These medications have a 50% coinsurance and require physician authorization.

Q: Is it up to the Individual to make sure there is NOT a generic drug available when they receive a prescription from a Doctor?

A: In most cases generics are always prescribed first by Kaiser Permanente physicians.

Q: If an employee is out of the area and is using emergency or urgent care, will the employee have to pay out of pocket then be reimbursed for services?

A: Your Kaiser Permanente medical plan provides 24/7, worldwide coverage for urgent and emergency care when traveling. Occasionally, non-plan providers will bill Kaiser Permanente directly for medical services rendered. In some cases, the member will be

required to pay for the emergency care or out-of-area urgent care and submit a claim form to request reimbursement.

Q: Why were the new rates for Kaiser approved? This was a substantial increase from the current rates.

A: Kaiser Permanente's 2012 rate increase was in line with the other health plans. A business decision was made by CalPERS and the other health carriers to use excess reserve money to help reduce the increase for these plans making the Kaiser rate look artificially higher than the other carriers.

Q: How does one enroll in the Senior Health Advantage with Kaiser and is there a age limit?

A: When a person becomes Medicare eligible, either at age 65 or from becoming disabled, he or she will need to first enroll in both Medicare Parts A and B before electing to enroll in Kaiser Permanente's Senior Advantage Plan.

Q: What is the non-formulary cost for Kaiser prescriptions?

A: The member will pay the full cost of Non-Formulary medications unless prescribed by his/her PCP and then the member would pay the brand copay.

Q: On the last slide for Kaiser the Member Services phone number was missing the last digit. The number shown was 800-464-400X. What is the correct contact number?

A: 1-800-464-4000

Q: Could you clarify the Kaiser chiropractic benefit? Is Kaiser providing chiropractic benefits only to Advantage participants or all members?

A: The actual Chiropractic covered benefit is only available to CalPERS members enrolled in the Medicare plan. Our basic members can receive discounts on chiropractic care and other services at kp.org/calpers. Choose the tab that says "Health and Wellness."

Q: If a member has another health plan (offered through spouse's employment) how does coordination of benefits work? Is one option (PPO) a better choice for coordinating benefits?

A: Members who have dual coverage can seek services from either insurance; however Kaiser Permanente will not coordinate benefits with another health plan unless the member has two Kaiser Permanente plans. If the member has two Kaiser Permanente plans then copays are generally waived, and the member will pay the lesser of the two copays for his/her prescription drugs. Kaiser members who have PPO and other HMO insurance can go to Kaiser Permanente for services and can submit a claim for to their

PPO or other HMO for a reimbursement of copayments. There is no guarantee that the PPO will pay for any or all of the copays.

Q: I understand that members can use the employer zip code versus their own zip code when enrolling. If the employee uses the employer zip code in say the LA area but live in the Other Southern CA area, can they still go to the doctor in the Other Southern CA area or are they restricted to the LA area?

A: Kaiser Permanente members are not restricted to using the facility near work or home. A Kaiser member may seek service at all of our facilities. Choose the one that is convenient for you!

Webinar Questions and Answers
CalPERS (General)

Q: Where can I find the 2012 Health Premiums for the CalPERS health plans?

A: The 2012 Premiums are currently available online and were included with the Open Enrollment packets mailed to members. These were also included in the 2011 Open Enrollment Circular Letter 600-048-11 which was mailed to employers in late July 2011. You may view the Open Enrollment Circular Letter at: www.calpers.ca.gov/eip-docs/employer/cir-ltrs/2011/600-048-11.pdf.

Q: What is the State of California contributing towards health benefits for its employees? What is the 2012 State annuitant (retiree & survivor) contribution?

A: The contribution for State employees is determined by individual bargaining unit negotiations. You can find information for State health premium contributions on the website of the Department of Personnel Administration at www.dpa.ca.gov.

The state's 2012 contribution for annuitants, based upon the 100/90 weighted average formula, is $566 for one-party, $1074 for two-party, and $1382 for family. These amounts may be modified based upon vesting years of service percentages.

Q: I am concerned about rates. Why are they so high? Blue Shield and Kaiser for HMO's?

A: Many factors are included in the rate development which include but are not limited to demographics, utilization, cost of health care in a specific region and administrative costs. CalPERS works diligently to provide our employers with the most comprehensive and cost effective health benefits package for their employees.

Q: Will there be any rate increase for Blue Shield/Access and Kaiser for 2012?

A: Rates in 2012 for HMO Basic plan members will rise by 7.0 percent for Kaiser and by 3.5 percent for Blue Shield Access+ and NetValue. The CalPERS 2012 health care rate package was adopted with an overall annual premium increase of 4.1 percent.

Q: What is the basis for which counties are placed in the CalPERS regions that determine premiums?

A: CalPERS began regionally pricing health premiums for public agency employers in 2005. The methodology used to form the regions created healthcare cost indices for each county (actual costs adjusted for age, sex and disease burden and other factors). Counties were then grouped into regions based on these cost indices, geography, and CalPERS membership in the county.

CalPERS periodically reviews the county composition of the regions to examine the continued validity of the regions and the counties within each region. The criteria used to determine whether a county's region assignment should be changed include: significant changes in cost or population, minimum region size, geography (contiguous counties in a region), and whether a county has experienced large cost fluctuations. Other considerations include potential or impending plan or network changes that could affect region costs.

Q: Will CalPERS ever adjust the premiums for families with more dependents? It is often felt that participants with less than three dependents are subsidizing large families.

A: CalPERS has instituted a market review research project to examine many facets of health benefit purchasing. One aspect of the project explores the feasibility and cost savings, if any, of more levels of premium tiering, and/or differences in premium depending on whether the employee covers a spouse dependent or a child dependent, for instance. Once the research is complete, the information will be presented to the CalPERS Board for consideration and direction.

Q: Why hasn't CalPERS adopted an EPO plan to serve in the most populated areas, like the Bay Area?

A: The EPO plan has HMO benefits and pricing using a special network of providers that BSC developed through direct contracts. Under this plan, members do not need to select a primary care physician, which has its pros and cons. It is not as cost-effective as an HMO and is intended to lower prices for more rural counties that would otherwise only have PPO access.

Q: Why two mailing dates and how will people be chosen for first or second date?

A: The Open Enrollment batch mailings are determined by a code assigned to the

employer. The reason that CalPERS separates the mailing by employer is so that employees of the same agency will receive their packets at approximately the same time. Also, sending out the mailings on two dates, helps balance the volume of phone calls to the CalPERS Employer Contact Center which in turn helps minimize potential hold time for callers.

Q: Will employees who currently do not take advantage of one of the CalPERS health plans, receive a newsletter so that they have access to the plan information with the mailings?

A: Members who are enrolled in 2011 will receive Open Enrollment information for the 2012 plan year. For those active and retired members who are not currently enrolled in a CalPERS health plan, information is available on the internet by visiting the CalPERS website at www.calpers.ca.gov or by calling health plans on the CalPERS numbers provided. Also, active employees may request information from their employers who are sent a supply of Open Enrollment information for distribution to their employees who wish to enroll.

Q: Please describe how employees will be able to access this webinar presentation. What other resources are available for information about the health plans?

A: The webinar and related materials will be posted on the CalPERS website. You may access all or portions of the on-demand video, audio, transcript, and presentation materials. The presentation will be available from September 2011 until the next update is posted, anticipated in August/September 2012.

In addition to the presentation, electronic versions or hardcopies requested of the following publications: the 2012 Health Benefits Summary (HBD-110), Health Program Guide (HBD-120), CalPERS Medicare Enrollment Guide (HBD-65). Please visit the "Forms & Publications Center" of the CalPERS website to access these publications or copy the following link: www.calpers.ca.gov/index.jsp?bc=/about/forms-pubs/home.xml.

Other information can be provided by the health plan partners on their microsites and CalPERS Health Plan Member Services Phone numbers, as provided in the webinar.

Q: Will the Health Plan Chooser have the correct links to the doctor list within each health plan, it currently does not link to the PPO plan doctors?

A: The CalPERS Health Plan Chooser does have a link to the HMO and PPO plan providers. The Health Plan Chooser can be found by visiting the following link:

www.calpers.ca.gov/index.jsp?bc=/member/health/2012-health-info/choosing/home.xml.

Simply fill out the profile information then click on the "Start Comparing Plans" tab at the bottom of the page, this takes you to the "Cost Estimate Page", click on "Doctors" tab

in the top left corner, scroll down on the left hand side of the page to choose the PPO plan where you wish to do your doctor search.

Q: If a member has another health plan (offered through spouse's employment) how does coordination of benefits work for each of the 3 plans? Is one option (PPO) a better choice for coordinating benefits?

A: If your spouse has a health plan outside of the CalPERS health benefits program, benefits can be coordinated. Your physician's office should be able to communicate how those benefits can be billed to coordinate benefits. HMO plans can be coordinated with an outside plan as well as the PPO plans.

Q: I understand that members can use the employer zip code versus their own zip code when enrolling. If the employee uses the employer zip code in say the LA area but live in the Other Southern CA area, can they still go to the doctor in the Other Southern CA area or are they restricted to the LA area?

A: The Kaiser Permanente and the CalPERS self-funded plans would not restrict use of doctors or facilities based upon the work or employer zip code. The Blue Shield plans generally have a 30-mile radius for the geographic service area, and if using an employer zip code, the family may need to use the employer zip area to receive services. It would be best to confirm eligibility with Blue Shield's Member Services Line.

Q: How long can one be outside of the state and receive care? Must one notify you when leaving the state/going on vacation?

A: Members who are traveling outside of their service area are covered for emergency services through their health plan. If it is possible, the member should call the number on their health plan card prior to receipt of services. If it is not possible to call prior to receipt of services, the health plan should be notified as soon as possible. It is not necessary to notify your health plan when leaving the state to go on vacation.

Q: Does one have to be retired in order to enroll into Medicare?

A: Medicare is a federal health insurance program that covers individuals age 65 and older. Medicare also covers some younger people with disabilities and people with End-Stage Renal Disease (ESRD is permanent kidney failure). If you are an active employee covered under a CalPERS-sponsored health plan you cannot be enrolled in a CalPERS-sponsored Medicare plan unless you have Medicare due to ESRD.

CalPERS retired members who qualify for premium-free Part A, either on their own or through a spouse (current, former, or deceased), must enroll in Part B at age 65, or as soon as they qualify due to disability. They must then enroll in a CalPERS-sponsored Medicare plan.

When you retire and are age 65 or older, or if you qualify for Social Security Disability

before age 65 and become eligible for premium-free Medicare Part A, you must sign up for Medicare Part B. At that time, you must also switch from your CalPERS Basic health plan to a CalPERS-sponsored Medicare plan or Managed Medicare plan (Medicare Advantage) in order to keep your health coverage through CalPERS.

Q: Please explain the mail order copay again. Currently I am paying $75 for 90-days, which would be $75 for a 30-day supply at the pharmacy?

A: In the 2011 plan design, the $75 charge for 90-day mail order is for the non-formulary brand name. If your non-formulary brand name was for a non-maintenance 30-day supply, the cost would be $45. In 2012, the 90-day mail order cost will be the sum of two 30-day prescriptions. The non-formulary 30-day prescription is going from $45 to $50, so your 90-day mail order cost will increase to $100 in 2012, provided that your non-formulary prescription does not have a Food and Drug Administration approved generic option.

Q: Do I understand correctly that the copay for brand name drugs is going up by $5, and we will be responsible for the difference between the generic and brand name drug?

A: The brand name drugs will be increasing by $5, brand name formulary medications will go from $15 to $20 in 2012, and brand name non-formulary medications will increase from $45 to $50. If there is a Food and Drug Administration approved generic option, and the member selects the brand name instead, the member will pay the generic prescription cost, plus the difference in the actual cost of medication between the generic and brand name medication. If the physician documents medical necessity of use of the brand name medication, and approval is obtained through the health plan, the brand name formulary or non-formulary cost will be charged, without the "member pays the difference" additional charge.

Q: What is a lifestyle enhancement medication?

A: These are medications such as Viagra and Cialis.

Q: Is it up to the Individual to make sure there is NOT a generic drug available when they receive a prescription from a Doctor?

A: Yes, it is a good idea to ask. Your doctor may write "Dispense as Written" as a matter of course, and not inquire with you about your health plan prescription benefit, cost, or restrictions you may have with your plan.